MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

105

C6462

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Ann Arundel

City or town Ft. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:
Station Hospital, Ft. Meade

How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ohio County .....

City or town Washington Courthouse
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #4
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Gideon P. Allen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Betty N Allen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 24 1929

8. AGE: Years	Months	Days	If less than one day
18	2	7	..... hrs. ..... min.

9. Birthplace unk
(Town, county, and state)

10. Usual occupation Regular Army Soldier

11. Industry or business U. S. Army

FATHER 12. Name unk

13. Birthplace

MOTHER 14. Maiden name unk

15. Birthplace

16. Informant U.S. Army

Address Ft. Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 5 47 (month) (day) (year)

Cemetery or crematory Washington Courthouse

Location Washington Courthouse, Ohio

18. Funeral director Lilly and Zeiler, Inc.

Address 403 S Wolfe, St. Balto. 31, Md.

19. 8/2 (Date rec'd by registrar) 19 47 C. W. Jedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 47 at 8:45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 47 to July 31 19 47 and that I last saw him alive on July 31 19 47

Immediate cause of death	DURATION
Asphyxia	5 min
Due to Laryngeal edema, acute	20 min
Due to Allergy to unknown substance	unknown
Other conditions Pulmonary edema (Include pregnancy within 3 months of death)	

Major findings of operation Tracheotomy Date of op. July 31 47

Autopsy results Laryngeal edema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE [illegible] MD M. D. or other

Address Ft. Mea. Ft. Meade, Md Date signed July 47

43 C. Gp.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05685

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years, 8 months, 7 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 10 years, 8 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 N. Arlington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

NORMAL BAKER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Normal Baker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
35	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Unknown

15. Birthplace

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial, ~~cremation, or removal~~ Which? Burial Date thereof 7/24/47 (month) (day) (year)

Cemetery or ~~crematory~~: Hospital

Location: Crownsville

18. Funeral director: Asylum Hospital

Address: Crownsville Md

19. July 21 1947 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947, at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 1936, to July 7 1947, and that I last saw him alive on July 7 1947.

Immediate cause of death: Lung Tuberculosis and Glandular Tuberculosis — DURATION: Known to us since June 20, 1945

Due to:

Due to:

Other conditions: Mental Deficiency Without Psychosis — Known to us since October 30, 1936
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed 7-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, including age. Physicians: please write the causes of death clearly and legibly. It is especially important.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

CERTIFICATE OF DEATH

05886

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: 222 West St. (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: William J. Baldree

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Helen B Baldree
6.(c) If alive, give age: 34 years
7. Birth date of deceased (mo., day, yr.): Aug 18, 1908

8. AGE: Years: 38 Months: 10 Days: 19 If less than one day ... hrs. ... min.

9. Birthplace: North Carolinia (Town, county, and state)
10. Usual occupation: Tavern Keeper
11. Industry or business: Restaurant & Bar.

FATHER
12. Name: John A. Baldree
13. Birthplace: N.C.

MOTHER
14. Maiden name: Martha Ann Moye
15. Birthplace: N.C.

16. Informant: Mrs Helen B. Baldree
Address: 222 West St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 9, 1947 (month) (day) (year)
Cemetery or crematory: Greenwood Cemetery
Location: Greenville, N.C.

18. Funeral director: Ben L. Hopping & Son
Address: 170-172 West St. Annapolis, Maryland

19. July 9, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1947, at 8:58 pm

21. I CERTIFY that death occurred on the date above stated. Postmortem Examined July 7, 1947

Immediate cause of death: Fracture of Skull

Due to: Hemorrhage from

Due to: Crushed Chest & punctured lung

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/7/47
Where did injury occur? near Davidsonville (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): 2 miles West of Pratt's Bridge
Means of injury: Air-plane crash landing Injured at work? No

23. SIGNATURE: John M. Claffy, M.D., Deputy Medical Examiner (M.D. or other)
Address: Annapolis, Md. Date signed: 7-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05687

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High School Grounds
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adolph L. Boettcher

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edith E. Boettcher
6.(c) If alive, his age: years
7. Birth date of deceased (mo., day, yr.): Jany. 27th 1882
8. AGE: Years: 65 Months: 5 Days: 25 If less than one day, hrs. min.
9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: Supt of Bld at
11. Industry or business: Annapolis High School
FATHER 12. Name: Henry J. Boettcher
13. Birthplace: Maryland
MOTHER 14. Maiden name: Frances Clark
15. Birthplace: Annapolis Md.
16. Informant: Mrs Adolph L. Boettcher
Address: Annapolis Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof July 23rd 1947 (month) (day) (year)
Cemetery or crematory: St Anns
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. July 22 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947 at 4.30a M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from June 30 1947 to July 21 1947 and that I last saw him alive on July 11 1947

Immediate cause of death: Cerebral Hemmhage — DURATION: June 30

Due to: Coronary Occlusion — July 20

Due to: Hypertension — 2 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C. Boeck M. D. or other
Address: Annapolis Md. Date signed: 7-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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05688

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 5 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anna Arundel

City or town: Woodlawn Beach (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Merris E. Brady

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	W	married

6.(b) Name of husband or wife: Nettie Brady

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Dec 27, 1889

8. AGE:

Years	Months	Days	If less than one day
57	7	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER

12. Name: Alfred Brady

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah Ward

15. Birthplace: Maryland

16. Informant: Mrs Nettie Brady

Address: Woodlawn Beach, A.A. Co., Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 29, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Mt. Zion, aa Co. Md.

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Md.

19. July 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h.. alive on 7.27.47. - 12:40 PM

Immediate cause of death	DURATION
Acute Alcoholism	
Due to	
Due to	
Other conditions Severe Burns Chest - upper Extremities - Abdomen	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7/27/47

Where did injury occur? Woodland Beach (City or town) aa Co. (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Cigarette burns (a) [illegible] Injured at work?

23. SIGNATURE: [illegible] - Dept. Medical Examiner M. D. or other

Address: Laurel Md Date signed 7/27/47

VS A15 6-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JUL 29 1947
BUREAU V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Anne Arundel
(a) ~~Baltimore City,~~ Maryland
(b) Street address 140 Market St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 05689
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 Market St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Matilda Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1876

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Brooklyn Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Stines
13. Birthplace Brooklyn Md

MOTHER
14. Maiden Name Lydia Brooks
15. Birthplace Brooklyn Md

16 (a) Informant Lola Davis
(b) Address 140 Market St

17 (a) Burial (b) Date thereof July 10-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Percy O. Wilson
(b) Address 1018 Bentley ave

19 (a) July 8-47 (b) A. W. Hebert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947, to July 7 1947, and that I last saw h[illegible] alive on July 3 1947.

Immediate cause of death	Duration
Intussusception of Kidneys	5 hrs.
Due to Total dislocation of the bony pelvis	
Due to Walking impaired 1 yrs. ago	
Other Conditions Pulmonary TBC - Quiescent	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Kavanaugh M. D.
Address 31 South Gate Date signed 7/9/47

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05690

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 26 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give neareat town)

Street No. 1230 Ashland (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BESSIE BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1888

8. AGE: Years	Months	Days	If less than one day
59	?	?	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial [illegible] (Burial, cremation, or removal. Which?) Date thereof July 5-47 (month) (day) (year)

Cemetery or crematory: Mount Calvary Cem

Location: A A County

18. Funeral director: Zetta Brooks

Address: 1408 Ashland ave

19. 7/3 19 47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 47 at 4:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 47, to July 1 19 47 and that I last saw her alive on July 1 19 47

Immediate cause of death	DURATION
General Paresis	Known to us since May 5, 1947
Due to:	
Due to:	
Other conditions: Luetic Aortitis (Include pregnancy within 3 months of death)	Known to us since May 5, 1947

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Crownsville, Maryland Date signed July 1, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Brady Smith Rivera Beach

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 95B

05691

Reg. Dist. No. 21

M

1. PLACE OF DEATH:

County Anne Arundel

City or town Chelsea Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Chelsea Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war WW

3.(a) FULL NAME Elsie Mae Sullington

3.(b) Social Security Number 216-20-3353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Homer J.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 29, 1908

8. AGE: Years 39 | Months 1 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Delta MD (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Grey

13. Birthplace Delta MD

MOTHER 14. Maiden name Elsie Mae Grey

15. Birthplace Delta MD

16. Informant Homer J. Sullington

Address Chelsea Beach MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/42 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie MD

18. Funeral director Wilson Funeral Home

Address 1217 Eutaw St

19. 7/14 1942 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1942 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1942 to July 13 1942 and that I last saw h[illegible] alive on July 12 1942

Immediate cause of death	DURATION
Rheumatic Heart Disease	10 years
Due to Rheumatic Fever	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Brady Smith M.D. M. D. or other

Address Rivera Beach, Md. Date signed 7/14/42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

05692

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel County

City or town: Dorsey, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 110 R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME

BUTLER - EDWARD H.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Mattie S. Butler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 23, 1881

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

9. Birthplace: Dorsey, Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Dennis Butler
13. Birthplace: Dorsey, Md

MOTHER
14. Maiden name: Evaline Culver
15. Birthplace: Maryland

16. Informant: Mattie S. Butler

Address: Box 110 R.F.D. Dorsey, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof July 19, 1947 (month) (day) (year)

Cemetery or crematory: Sts. Rest

Location: Dorsey, Md.

18. Funeral director: Mrs. Lew. H. Holland

Address: 1631 Druid Hill Ave.

19. 7/19 (Date rec'd by registrar) 1947 C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1947 to July 16, 1947 and that I last saw h ..... alive on July 16, 1947

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since admission
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: David Nonnenstern M.D. M. D. or other

Address: Crownsville, Maryland Date signed 7/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05693

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Maryland

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Quincy Place (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN COOK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Ada Cook

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	12	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7/5/47 (month) (day) (year)

Cemetery or crematory: Not Known yet

Location: Washington D.C.

18. Funeral director: Johnson & Jenkins

Address: 2653 Ga. Ave N W

19. July 3 1947 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 47 to July 2 19 47 and that I last saw h im alive on July 2 19 47

Immediate cause of death	DURATION
General Paresis	Known to us since June 10, 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerstein M. D. M. D. or other

Address: Crownsville, Maryland Date signed: July 2, 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b

05694

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Moore Crane

3.(b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6th 1904

8. AGE: Years: 43 Months: 3 Days: 17 If less than one day: hrs. min.

9. Birthplace: Westfield Mass.
(Town, county, and state)

10. Usual occupation: Director Adult Hall

11. Industry or business: U. S. Government Ward D.C.

FATHER
12. Name: William P. Crane
13. Birthplace: Huntington Mass.

MOTHER
14. Maiden name: Sarah A. Kane
15. Birthplace: South Hampden Mass.

16. Informant: William P. Crane
Address: Springfield Mass.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: July 23rd 1947 (month) (day) (year)

Cemetery or crematory:
Location: Westfield Mass.

18. Funeral director: John M. Taylor Sr.
Address: Annapolis Maryland.

19. July 23, 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1947, at 10.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1947 to July 23 1947 and that I last saw h... alive on July 23 1947.

Immediate cause of death
1. Generalized Peritonitis — DURATION: Since 7/18/47
Due to: Rupture of Adenocarcinoma of the Body of the Uterus — DURATION: Since 7/18/47
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Rupture of Adenocarcinoma of the Body of the Uterus — Date of op.: 7/19/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed: 7/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 e

05695

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 149 Pri Geo St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza Catherine Dove

3.(b) Social Security Number

4. Sex 7

5. Color or race W.

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Louis H. Dove

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 23 1877

8. AGE: Years 69 Months 9 Days 24 If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, County, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Joseph Puckett

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Welleams

15. Birthplace Maryland

16. Informant Mrs Robert L. Jones

Address 149 Pri Geo St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 1947 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. July 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1947 to July 20 1947 and that I last saw h[illegible] alive on July 20 1947

Immediate cause of death Uraemia — DURATION 24 hrs

Due to Ca. Intestinal Neoplasm — DURATION 4 months

Due to Carcinomatosis — DURATION about 6 months

Other conditions Primary site: Sigmoid flexure of large intestine. (9/2/47 J.S.)
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE J. Oliver Purdie M. D. or other

Address Annapolis Md Date signed 7/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
JUL 24 1942
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

C6463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years, 4 months, 17 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 12 years, 4 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 720 Ensor Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME NETTIE ELLISON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us 1886

8. AGE:

Years	Months	Days	If less than one day
61	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Edgar Lucas
13. Birthplace: Virginia

MOTHER
14. Maiden name: Marion Robinson
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2-47 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: A. A. Co

18. Funeral director: Rayner Sanders

Address: 1412 E. Preston St

19. 8-1 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47 at 5:36 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1935 19 to July 31 19 47 and that I last saw her alive on July 31 19 47

Immediate cause of death	DURATION
Hypertensive cardiovacular disease	
Due to: Known to us since August 26, 1941	
Due to:	
Other conditions: Mental Deficiency Known to us since March 14, 1935	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05696

46L

CERTIFICATE OF DEATH

Reg. Dist. No. 23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Millersville, Md. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Whitneys Landing Road

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: JOHN GELLERT

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Christine Gellert

(nee) Orzchehowski 6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): June 23, 1871

8. AGE: Years	Months	Days	If less than one day
76	0	9	....hrs. ....min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Farmer (retired)

11. Industry or business: Own Farm

FATHER 12. Name: Unknown

13. Birthplace: Germany

MOTHER 14. Maiden name: Elisabeth Ochs

15. Birthplace: Poland

16. Informant: Jacob Gellert

Address: Millersville, Md., R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1947 (month) (day) (year)

Cemetery or crematory: Meadow Ridge

Location: Washington Blvd. Dorsey Rd.

18. Funeral director: THOMAS W. SINGLETON

Address: Glen Burnie, Md.

19. 7-3 19 41 (Date rec'd by registrar) M.R. DeLoa Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 19 47, to July 2 19 47

and that I last saw h 4 alive on July 1 19 47

Immediate cause of death	DURATION
Carcinoma of the Stomach	18 months
Due to: Sore	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Buckingham M.D.

M. D. or other

Address: Glen Burnie Md Date signed: July 3, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

05697

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hours, 16 minutes.

Hospital, institution, or street address where death occurred: U.S. Naval Hospital, Annapolis, Maryland

How long in hospital or institution? 11 hours, 16 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 165 Main Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GLASS, Margaret Veronica

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George William Glass

CCS USN (Retired Inactive) 6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 4 January 1882

8. AGE:

Years	Months	Days	If less than one day
65	5	22	..... hrs. ..... min.

9. Birthplace: Newport, Rhode Island (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None.

FATHER

12. Name: Michael O'Brien

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary O'Brien

15. Birthplace: Ireland

16. Informant: Mrs. Bernard Engelke

Address: 165 Main St., Annapolis, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St Annapolis, Md.

19. July 28 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 July 1947 at 1131 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12:15 A.M. 26 July 1947 to 11:31 A.M. 26 July 1947 and that I last saw her alive on 26 July 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	15 hrs.
Due to: Hypertension	20 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas W. Green Thomas W. Green, Lt(jg)(MC)USNR. M. D. or other

Address: Family Clinic, USNH, Annapolis, Md. Date signed: 7-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05709

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hrs.

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3435 Park Heights Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Philip Golob

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Sarah

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1879

8. AGE: Years: 67 Months: ~~2~~ Days: ~~one~~ If less than one day: hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden name: Not Known
15. Birthplace: Russia

16. Informant: ~~Sister~~ Family Records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-29-47 (month) (day) (year)

Cemetery or crematory: Rosedale

Location: Balt. Co.

18. Funeral director: Jack Lewis Inc.

Address: 2100 Eutaw Place

19. 7/29 19 47 A.D. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 47 at 6 15 A.M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 , to 19

and ~~that I last saw h~~ alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie M.D.
Acting M.E.
M. D. or other

Address: Annapolis, Md. Date signed: July 28, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

05699

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Snowden Town, Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Snowdentown, Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Griffith's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Levi Harrison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 22 1919

8. AGE: Years: 27 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William Harrison
13. Birthplace: Md

MOTHER
14. Maiden name: Annie Marshall
15. Birthplace: Md

18. Informant: Naomi Harrison
Address: Glenburnie R. A. Box Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/16/47 (month) (day) (year)
Cemetery or crematory: Balto National
Location: Balto City

18. Funeral director: Isaiah L. Brown & Son
Address: 108 W Montgomery St

19. 7/15 19 47 (Date rec'd by registrar) Alw. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1947, at 8 45 P. M

21. I CERTIFY that death occurred on the date above stated; [redacted]
Patmos Fem 19 Examination
at [redacted] July 14, 1947

Immediate cause of death	DURATION
Due to: Shot-gun wound in left chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: July 14, 47
Where did injury occur? Snowdentown (City or town), A.A. (County), Maryland (State)
Injured at home, farm, industry, public place (where?): in yard at home
Means of injury: Shot-gun Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 7/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05700

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 405 Giddings Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary R. Hartmann

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Hartmann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 14, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	8	25		

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Judolph Stratemeyer
13. Birthplace: Germany
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Mrs. Anna Ravenscroft
Address: W. Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/47 (month) (day) (year)
Cemetery or crematory: Mt. Carmel Cemetery
Location: Baltimore, Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.
19. July 11, 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947 at 12 N M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1947 to July 9, 1947 and that I last saw h alive on July 9, 1947.

	DURATION
Immediate cause of death: Cardio Vascular Failure	about 3 days
Due to: Acute Dilatation of Heart	3 wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Parsons M. D. or other
Address: Annapolis, Md. Date signed 7/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 12 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

05701

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A.A. Co.

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A. Co.

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Whitney Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LeRoy Haslup.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife late Catherine.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15th 1868.

8. AGE: Years	Months	Days	If less than one day
78-11-17			..... hrs. ..... min.

9. Birthplace A.A. Co. Maryland

(Town, county, and state)

10. Usual occupation Railroad Fireman.

11. Industry or business Retired

MOTHER FATHER

12. Name Leroy J. Haslup.

13. Birthplace Baltimore.

MOTHER

14. Maiden name Margaret Frankland

15. Birthplace Philadelphia Pa

16. Informant Mr Charles L. Haslup

Address 1745 So Charles St

17. (Burial, cremation, or removal. Which?) Burial Date thereof 7 (month) 5 (day) 47 (year)

Cemetery or crematory Cedar Hill Cem.

Location Elkton Highways

18. Funeral director John C Brown & Son

Address 90-96 Wallace St

19. 7/5 1947 (by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1947, at 11-40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1947 to July 2 1947 and that I last saw h..... alive on July 2 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs.
Due to	
Due to	
Other conditions Nephritis	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas L Bell M.D. M.D. or other

Address Elkton Date signed 7-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87d

CERTIFICATE OF DEATH (CB)

05702 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: N. C. County: [redacted]
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 430 N. Boundry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Conrad Lee Hill

3.(b) Social Security Number: UNKNOWN.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Pauline Benson
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): March 25-1901

8. AGE: Years: 46 | Months: 4 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Leakesville, N.C.
(Town, county, and state)

10. Usual occupation: Superintendent (Industry)

11. Industry or business: Cannon Textile Company.

FATHER
12. Name: Tommy Hill
13. Birthplace: N. C.

MOTHER
14. Maiden name: Anna Redmond
15. Birthplace: N.C.

16. Informant: Lt. P. B. Hill
Address: Fort George G. Meade. Md.

17. Ship To (Burial, cremation, or removal. Which?) Date thereof: July 28, 1947 (month) (day) (year)

Cemetery or crematory: Peeler Funeral Home.

Location: Salisbury N. C.

19. Funeral director: Homer S. Singleton

Address: Glen Burnie, Md.

19. 7-28-47 (Date rec'd by registrar) M. R. DeHaven Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 47, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [redacted] 19[redacted], to [redacted] 19[redacted]
and that I last saw h[redacted] alive on [redacted] 19[redacted]

	DURATION
Immediate cause of death: Acute circulatory diseases.	Sudden
Due to: Coronary sclerosis	?
acute congestion of lungs.	
Due to: sclerosis of aorta and	
Other conditions: cerebral vessels.	
cardiac hypertrophy	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: See No 21
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work?

23. SIGNATURE: Kenelm H. Fowler Jr. M.D.
(Attending physician, medical examiner, M. D., or other)
Address: Glen Burnie, Md. Date signed: 7/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

05703

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Bloomsbury Square
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ella Catherine Holman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Grover J. Holman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15, 1889.

8. AGE: Years: 58 Months: 0 Days: 12 If less than one day: hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: John Pickard
13. Birthplace: England

MOTHER
14. Maiden name: Ellen Gardiner
15. Birthplace: New York

16. Informant: Mrs. Ellen C. Boyer

Address: 25 Bloomsbury Sq. Annapolis

17. (Burial, cremation, or removal. Which?) Burial, Date thereof July 30 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. July 28 1947 (Date rec'd by registrar) W. Brunck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947 at 10½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1941 to July 27 1947 and that I last saw h[illegible] alive on July 26 1947

	DURATION
Immediate cause of death: Carcinoma, Uterus	1 yr
Due to: Pelvis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Boyer M. D. or other

Address: Annapolis Md. Date signed: 7-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 30 1940
BUREAU V.M.

05704

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Hanwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:
None - Hanwood

How long in hospital or institution? [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Hanwood
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Birdsville
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Elroy Hopkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 4, 1947

8. AGE:

Years	Months	Days	If less than one day
0	3	22	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: James Henry Hopkins
13. Birthplace: Hanwood, Md.

MOTHER
14. Maiden name: Margaret Galloway
15. Birthplace: Owensville, Md.

16. Informant: James Henry Hopkins
Address: Hanwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26, 1947 (month) (day) (year)

Cemetery or crematory: Maid Stds Home

Location: West River, Md

18. Funeral director: E. A. Stanley & Son

Address: Galesville, Md.

19. 7/29/47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased~~ from ..... 19..... to ..... 19.....
and that I last saw ~~him~~ alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxiation	
Due to: suffocation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of July 26, 1947

Where did injury occur? Hanwood (City or town) A. A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: suffocated in sleep Injured at work?

23. SIGNATURE: E. Preston Ritchie, Jr. M.D.
Acting M. E. or other

Address: Annapolis, Md. Date signed: July 26, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05705 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years 5 months, 2 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 9 years, 5 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1206 N. Caroline (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RAYMOND HOWARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1904

8. AGE: Years	Months	Days	If less than one day
43	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Charles Howard

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary James

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof 7-11-47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: A. A. Co., Maryland

18. Funeral director: William A. Johnson

Address: 916 Penna. Ave. Bacto-1, Md.

19. 7/9 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 8:10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 4 1938 to July 6 1947 and that I last saw him alive on July 6 1947.

Immediate cause of death	DURATION
Lung tuberculosis	
Known to us since May 15, 1947	
Due to:	
Due to:	
Other conditions: Schizophrenia, Hebephrenic Type (Include pregnancy within 3 months of death)	Known to us since

Major findings of operations: Febr. 4, 1938 Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 7-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

05706

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: A A Co.

City or town: Shoreacres, Annex P.O. A.A.Co. Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: ANNE ARUNDEL

City or town: Shoreacres, Annex PO

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lillie May Huss

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John E. Huss

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): January 20, 1873

8. AGE: Years: 72 Months: 5 Days: 18 If less than one day: hrs. min.

9. Birthplace: Baltimore Md. (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Charles Higgins

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Kate Higgins

15. Birthplace: Baltimore Md

16. Informant: John E. Huss

Address: Shore Acres Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 7/11/47 (month) (day) (year)

Cemetery or crematory: London Park Cem.

Location: Baltimore Md

18. Funeral director: Tilghman & Roe

Address: 1217 Druid Lane

19. 7-9-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 47 at 12.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47, to July 8 19 47

and that I last saw h alive on June 15 19 47

	DURATION
Immediate cause of death	
a. Pulmonary Edema	30 min.
Due to: Arteriosclerotic C. V. disease	1 yr. +
Due to:	
Other conditions: overweight	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. J. Klauans MD M. D. or other

Address: Annapolis, Md. Date signed: 7/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

05707 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Pasadena.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Sadie B. Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White	Widow.

6.(b) Name of husband or wife: Andrew A. Jackson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 12 - 1882

8. AGE:

Years	Months	Days	If less than one day
64	9		hrs. min.

9. Birthplace: Virginia (Deltaville, ?)

(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER

12. Name: James Hart

13. Birthplace: Virginia

MOTHER

14. Maiden name: Mary - ??

15. Birthplace: Virginia

16. Informant: Mrs. Barry E. Burke

Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1947 (month) (day) (year)

Cemetery or crematory: Carter

Location: Deltaville Middlesex Co. Va.

18. Funeral director: A. Howard Evans

Address: 140 S. Charles St

19. 7/14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to July 11 1947, and that I last saw h[illegible] alive on 7/11/47 1947

Immediate cause of death	DURATION
Mitral Insufficiency	9 mos.
Due to: Interstitial Nephritis	9 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Lauterbach M. D. or other

Address: Glen Burnie Md. Date signed: 7/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 05708

CERTIFICATE OF DEATH

Reg. Dist. No. 23

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly (I) (T) MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Anne Arundel

City or town Garland (Linthicum Heights, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Garland (Linthicum Hghts, Md)
(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Poplar Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MARY B. JENKINS

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Francis K. Jenkins deceased. 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 26, 1866

8. AGE: Years	Months	Days	If less than one day
80	10	5	... hrs. ... min.

9. Birthplace Patterson, N.J.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Wise

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mr. William F. Jenkins

Address Garland (Linthicum Hghts, Md.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1947 (month) (day) (year)

Cemetery or crematory Montrose Cemetery

Location Delaware County, Pa.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 7-2 1947 MR DeHaven
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47, at 4.55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10/47 19... to July 1st 19 47 and that I last saw h... alive on June 30th 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	
Due to	
Other conditions Diabetes Mellitus	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Thos. W. Alexander M. D. or other

Address Glen Burnie Date signed 7/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

057109

92b

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ months

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war ..... ✓

3.(a) FULL NAME

JOHNSON - RUTH #2

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years	Months	Days	If less than one day
37			..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Factory & Houseworker

11. Industry or business

FATHER — 12. Name: Walter Johnson

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Lennie Lloyds

15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial #
(Burial, cremation, or removal. Which) Date thereof July 21th 47
(month) (day) (year)

Cemetery or crematory Mt Calv Cemetary

Location Brookland Md

18. Funeral director Elroy O Wilson

Address 1000 Brantley Ave

19. July 21 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 19 47, at 8:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 19 47, to July 17, 19 47 and that I last saw her alive on July 17, 19 47

Immediate cause of death	DURATION
Mitral Stenosis	Known to us since admission 3/5/47
Due to: Cardiovascular Disease	
Due to:	
Other conditions: Psychosis with Cardiovascular disease (Include pregnancy within 3 months of death)	3/5/47

Major findings of operations: —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jacob Carpenter M. D
M. D. of other

Address Crownsville, Maryland Date signed 7/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

#10299

Ruth Johnson
Admitted March 5, 1947

Died July 18, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

05711 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 hours
Hospital, institution, or street address where death occurred: Rfd 2 Box 535-C
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Edgewood Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rfd 2 Box 535-C
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence Evelyn Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 7-9-47

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ____ min.

9. Birthplace: Edgewood Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Winfield Jones
13. Birthplace: Eastport Md.

MOTHER
14. Maiden name: Vergie Carr
15. Birthplace: Edgewood, Md

16. Informant: Mother
Address: Rfd 2 Box 535-C Edgewood

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-10-47 (month) (day) (year)
Cemetery or crematory: Brookneal
Location: Edgewood, Md.

18. Funeral director: Mrs Charles E Hicks
Address: 45 Northwest Annapolis

19. July 10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 19 47 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 47 to July 9 19 47 and that I last saw h[illegible] alive on July 9 19 47

Immediate cause of death: Prematurity — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M.D. M. D. or other
Address: 17 Carroll St. Date signed: 7-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

05712

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Route #1 - New Cut Road, Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred: Route #1, Box 134 Severn P.O., Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A. Co.

City or town: Rural - (Glen Burnie)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1 Box #134 Severn P.O. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #I

3.(a) FULL NAME: Stephen Kuczinski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie Julie Kuczinski nee - Andrews 6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.): December 15 - 1896

8. AGE: Years	Months	Days	If less than one day
50	6	6	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Disabled Veteran

11. Industry or business: None

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs. Jennie Kuczinski

Address: New Cut Road (Near Glen Burnie

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland.

16. Funeral director: John W. Singleton

Address: 200 Crain Highway S.W. - Glen Burnie, Md.

19. 7/23 19 47 (Date rec'd by registrar) M.R. Dalba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 47, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from accident 19 47, to July 20 19 47

and that I last saw h... alive on 7/20/47 19....

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Gustave Paulsen M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: 7/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legi

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VS A15


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JUL 24 1947
BUREAU F.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

05713

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pasadena P.O
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Carrollton Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME J Melvin Layton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	SINGLE

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-1-1924

8. AGE: Years	Months	Days	If less than one day
23	—	3	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: School
11. Industry or business
FATHER 12. Name: Robert Layton
13. Birthplace: Va
MOTHER 14. Maiden name: Ada Norman
15. Birthplace: Va
16. Informant: Ada Layton
Address: 516 N. Carrollton ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 7 47 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Park
Location: Baltimore County Md
18. Funeral director: William A Jackson
Address: 916 Penna ave.
19. July 5 1947 (Date rec'd by registrar) A. W. Hedrick Asst. State Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1947 at 5 30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination ~~to~~ ~~and that I last saw him alive on~~ 19.....

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7/4/47
Where did injury occur? Pasadena (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Beachwood Park Pasadena
Means of injury Drowning Injured at work? no

23. SIGNATURE: John M. Cleffy M.D. Deputy Medical Examiner
M. D. or Coroner
Address: Annapolis Md Date signed 7/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

956

05714

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Fourth St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cecelia Lewnes

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Sam Lewnes
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 16 1891
8. AGE: Years 55 | Months 7 | Days 2 | If less than one day ..... hrs. ..... min.
9. Birthplace: Greece (Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: James Mandrios
13. Birthplace: Greece
MOTHER 14. Maiden name: Mary Mandrios
15. Birthplace: Greece
16. Informant: Sam Lewnes
Address: Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. July 20 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947 at 8 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to July 18 1947
and that I last saw her alive on July 18 1947

	DURATION
Immediate cause of death: Rheumatic Cardio Vascular disease - Angina	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

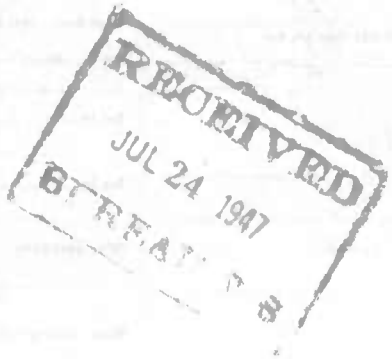
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Edgewood Md. Date signed 7/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or incomplete page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-75M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JUL 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05716

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 133 Market St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James A. Lloyd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Lloyd

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept 3, 1886

8. AGE: Years	Months	Days	If less than one day
60	10	6	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business

FATHER
12. Name: Thomas M. Lloyd
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Ward
15. Birthplace: Maryland

16. Informant: Mrs Mary E Lloyd
Address: 133 Market St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11,47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. July 10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 47 at 7 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 47 to July 8 19 47 and that I last saw h[illegible] alive on July 8 19 47

Immediate cause of death	DURATION
Cardio Vascular Failure	Several Days.
Due to: Acute Coronary Thrombosis 3 Wks +	
Due to: Acute Cerebral Embolism 2 Wks	
Other conditions: with right sided Hemiplegia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Oliver Purnell M. D. or other

Address: Annapolis Md Date signed 7/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

05715

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 Cleveland Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William E. Miller

3. (b) Social Security Number: 212 05 0680

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elna I. Miller
(Nee Cook) 6.(c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.): May 8, 1893.

8. AGE: Years	Months	Days	If less than one day
54	2	8	....hrs. ....min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)
10. Usual occupation: Telephone Installer(Retired)
11. Industry or business: C & P Telephone Co.
FATHER 12. Name: William A.Miller
13. Birthplace: Frederick Co. Md.
MOTHER 14. Maiden name: Mary E. Hose
15. Birthplace: Frederick Co, Md.
16. Informant: Mrs. Elna I. Cook
Address: Linthicum Heights, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29,47. (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Mountain Road, A.A.Co. Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. 7-28-47 (Date rec'd by registrar) 19.... M.R. Dellha Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 19 47 at 2:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 19 47 to July 26 19 47 and that I last saw h./m. alive on July 26 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE.	
Due to HYPERTENSION	
Due to ARTERIOSCLEROSIS	
Other conditions CONGESTIVE HEART FAILURE	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry Bangan M.D.
M. D. or other
Address Glen Burnie Date signed 7/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

131a

05717

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton Md Near Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Odenton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza Morgan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Franklin Morgan
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Oct 26 1867

8. AGE: Years	Months	Days	If less than one day
79	9	10	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business
FATHER 12. Name: Robert Smith
13. Birthplace: Virginia
MOTHER 14. Maiden name: Ellen Ruffon
15. Birthplace: Virginia
16. Informant: Franklin Morgan
Address: Odenton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1947 (month) (day) (year)
Cemetery or crematory: Bacons Cemetery
Location: Near Laurel Md
18. Funeral director: Ridgely Selby
Address: 401 Wash. Blvd Laurel Md
19. July 19 1947 (Date rec'd by registrar) Clara Hasbup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1947 at 11 9 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-14 1947, to 11/16 1947
and that I last saw h[illegible] alive on 11/16 1947

Immediate cause of death	DURATION
Myocarditis - Senile	7
Cystitis Chronic	
Intestinal Stasis	
Colon Stasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. M. [illegible] M.D.
Address: Laurel Md Date signed: 7/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05718

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 Lawn
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM MURRAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years	Months	Days	If less than one day
38	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business:

FATHER
12. Name: John unk
13. Birthplace: unk

MOTHER
14. Maiden name: Hattie Robertson
15. Birthplace: unk.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem.

Location: H. H. Lee.

18. Funeral director: Archibald A. Goddis

Address: 2101 N. Eutaw St. Balto

19. 7/17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1947 to July 9 1947 and that I last saw him alive on July 9 1947

Immediate cause of death: General Paresis — DURATION: Known to us since June 13, 1947

Due to:

Due to:

Other conditions: General Paresis — Known to us since June 13, 1947
(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David Hagerstown M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 7/9/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10465

Murray - William
Admitted June 13, 1947
Died July 9, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05734

AC

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Stoney Run Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore city
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 900 - Hoshleuen ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward Ellsworth Van Newkirk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife: Ida Kelbel (dead)
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 2nd 1866

8. AGE:

Years	Months	Days	If less than one day
80	10	24	... hrs. ... min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)
10. Usual occupation: Oil Compounder
11. Industry or business

FATHER
12. Name: Edward Newkirk
13. Birthplace: Baltimore city, Md.

MOTHER
14. Maiden name: Amanda Kirby
15. Birthplace: Baltimore city, Md.

16. Informant: Mrs. Louis Newkirk (son)
Address: Lansdowne, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 7 29 47 (month) (day) (year)
Cemetery or crematory: BALTIMORE
Location: East End North Ave.
18. Funeral director: John F. Deany, Inc.
Address: 215 Light St.
19. 7/29 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 19 47 at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 19 47 to July 26 19 47 and that I last saw him alive on 7/24/47 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Hypertension	4 years
Due to: Senile arteriosclerosis	6 years
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Baudenstedt M. D. or other
Address: Glen Burnie, Md. Date signed 7/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05719

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: County Anne Arundel
City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Chase Home Maryland Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County ~~Anne Arundel~~ Charles
City or town ~~Annapolis~~ La Plata (If outside city or town limits, write RURAL and give nearest town)
Street No. ~~Chase Home~~ (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jeannette Page
3.(b) Social Security Number

4. Sex female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Oct. 7, 1864
8. AGE: Years 82 Months 8 Days 27 If less than one day ... hrs. ... min.
9. Birthplace White Plains, Charles Co., Md (Town, county, and state)
10. Usual occupation retired
11. Industry or business
FATHER 12. Name Horatio Clagett Page
13. Birthplace Unknown
MOTHER 14. Maiden name Mary Anne Briscoe
15. Birthplace Unknown
16. Informant W. H. Hawkins
Address La Plata, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-1947 (month) (day) (year)
Cemetery or crematory Mt. Rest
Location La Plata, Md.
18. Funeral director Hunt & Ryon
Address Waldorf, Md.
19. July 5, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 10:45 A.M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h... alive on~~ July 4 1947

	DURATION
Immediate cause of death Acute Dilatation of Heart	sudden
Due to	
Due to Chronic Myocarditis	unknown

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy, M.D., Deputy Medical Examiner M. D. or other
Address Annapolis, Md Date signed 7/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

05720

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bladen St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Randolph Phipps

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife none
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) July 25th 1901
8. AGE: Years 45 Months 11 Days 22 If less than one day ...... hrs. ...... min.
9. Birthplace A. A. Co Md
(Town, county, and state)
10. Usual occupation Taxi Service (Self)
11. Industry or business
FATHER 12. Name Joseph E. Phipps
13. Birthplace A A Co Md
MOTHER 14. Maiden name Margaret Long
15. Birthplace A A Co Md
16. Informant Mrs Pearl Asquith
Address Edgewater A A Co Md
17. Burial Date thereof July 20th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor Son
Address Annapolis Md.
19. July 20 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 1 30 P M
21. I CERTIFY that death occurred on the date above stated; ~~that~~ Postmortem Examination ~~on~~ July 17 1947

	DURATION
Immediate cause of death	
Due to Coronary embolism	sudden
Due to Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 7/18/47

VS A15 9-45-15M

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JUL 24 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164c

05722

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Snowdentown, Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Snowdentown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Griffith's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Daniel Elijah Queen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 - 1916

8. AGE: Years 30 | Months | Days | If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
12. Name Elias Queen
13. Birthplace Md
14. Maiden name Catherine Muckett
15. Birthplace Md

16. Informant Elias Queen
Address Snowdentown A.A.Co.Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/47 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18. Funeral director Isaiah L. Brown & Son
Address 108 W. Montgomery St

19. 7/15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at Midnight

21. I CERTIFY that death occurred on the date above stated, from Post mortem Examination

Immediate cause of death	DURATION
Due to Shot-gun wound	
Due to in right chest	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 7/13/47
Where did injury occur? Snowdentown, A.A., Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) in bed-room at home
Means of injury shot. gun Injured at work? No

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 7/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

05721

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Snowden Town, Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Snowden Town, Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Griffiths Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Viola Queen

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	negro	Married

6.(b) Name of husband or wife: E. Queen
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.):

8. AGE:

Years	Months	Days	If less than one day
45			hrs. min.

9. Birthplace: a a Co, md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: Sylvester Queen
13. Birthplace: md
MOTHER 14. Maiden name: Emma —
15. Birthplace: md
16. Informant: Milton Queen
Address: Glenburnie, md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 47 (month) (day) (year)
Cemetery or crematory: Mt Carmel Cem
Location:
18. Funeral director: James A Stayes
Address: 142 Wood St
19. 7/16 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1947 at 9 15 P M
21. I CERTIFY that death occurred on the date above stated: Postmortem Examination 1947
July 13 1947

Immediate cause of death	DURATION
Homicide	
Due to: Shot gun wounds	
Due to: in chest and face	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Homicide Date of 7/13/47
Where did injury occur? Snowden Town P.O., Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) next door to home
Means of injury shot-gun wounds Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 7/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05723

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, Institution, or street address where death occurred:
911 West St. Annaolis Md.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 911 West St. Annapolis Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Frances Randall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: Robert John Randall

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): July 16, 1863

8. AGE: Years	Months	Days	If less than one day
64	7	7	____ hrs. ____ min.

9. Birthplace: Westriver Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: None

FATHER
12. Name: James Whittington
13. Birthplace: West river A. A. Co. Md.

MOTHER
14. Maiden name: Marie Forbes
15. Birthplace: West river

16. Informant: Mr Leonard Randall
Address: 911 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 1947 (month) (day) (year)

Cemetery or crematory: National

Location: West street extended

18. Funeral director: Mrs. Edna C. Kirk

Address: 43-45 Northwest Street

19. July 28 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1947 at 3:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw her alive on July 23, 1947

Immediate cause of death	DURATION
Cardiac Failure	I day
Due to Hypertensive Cardio Vascular Disease	7 Mons.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 40 Northwest Street Date signed: 7-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05724

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 WEEKS
Hospital, Institution, or street address where death occurred:
91 COLLEGE CREEK TERR.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: ANNE ARUNDEL
City or town: ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 91 COLLEGE CREEK TERR.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: MAGGIE LAVERNE Richmond

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	Col.	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): NOV. 19, 1946

8. AGE: Years	Months	Days	If less than one day
0	8	7	— hrs. — min.

9. Birthplace: HOUSTON TEXAS.
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: ROGER L Richmond.
13. Birthplace: Liberty Texas

MOTHER
14. Maiden name: MARY JANE Richmond.
15. Birthplace: Maurice, La.

16. Informant: MARY JANE Richmond
Address: 91 COLLEGE CREEK TERR.

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: August 3, 1947
(month) (day) (year)

Cemetery or crematory: Unknown
Location: Houston, Texas

18. Funeral director: McCharles P. Fick
Address: 45 Northwest St Annapolis Md

19. July 29 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 26 1947 at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 26 1947 to JULY 26 1947 and that I last saw h.. alive on JULY 26 1947

Immediate cause of death: BRONCHOPNEUMONIA — DURATION: 36 hrs
Due to: PERTUSSIS
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Ernst R Moeller M.D.
M. D. or other
Address: Naval Hosp Annapolis Md Date signed: 7-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 30
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 21 05725

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)

Street No.: 408 Leland St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Angus Leldon Robinson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1916

8. AGE: Years: 31 Months: 2 Days: 25 If less than one day: hrs. min.

9. Birthplace: Eastport, Md. (Town, county, and state)

10. Usual occupation: Cobbler at the U. S. Naval Academy

11. Industry or business:

FATHER 12. Name: Harry Clifton Robinson

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Mary Rebecca Hopkins

MOTHER 15. Birthplace: Annapolis, Md.

16. Informant: Louis F. Robinson

Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8th 1947 (month) (day) (year)

Cemetery or crematory: St. Annes

Location: Annapolis, Md.

18. Funeral director: John M. Taylor, Son

Address: Annapolis, Md.

19. July 7, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1947 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; to the best of my knowledge, death was due to the cause(s) and manner stated below; that I last attended deceased on July 4, 1947; that I viewed the body after death on

	DURATION
Immediate cause of death: Coronary Embolism	sudden
Due to: Coronary Sclerosis	untimy
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M. D. or C.

Address: Annapolis, Md. Date signed: 7/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 05726

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 620 Chesapeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Thomas Rodowsky

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Barbara A. Rodowsky

6.(c) If alive, give age: yrs.

7. Birth date of deceased (mo., day, yr.): July 2nd 1884

8. AGE: Years	Months	Days	If less than one day
63		6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Groceryman

11. Industry or business

FATHER — 12. Name: Thomas Rodowsky

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Edward J. Rodowsky

Address: 620 Chesapeake Ave Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11th 1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemt.

Location: Baltimore Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. July 11 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to July 8 1947 and that I last saw h. 1m alive on 7/8/47. 1947

Immediate cause of death	DURATION
Arteriosclerotic C.V. disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Lambert M. D. or other

Address: Eastport Md. Date signed: 7/9/47.

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05727

61

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rivera Beach (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -- Life --

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rivera Beach (If outside city or town limits, write RURAL and give nearest town)

Street No.: - (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: James C. Rowe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: -Mary Rose

- 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	29	hrs. min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)

10. Usual occupation: Tool Room Clerk

11. Industry or business: Fairfield Ship Yards

FATHER — 12. Name: William Rowe

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Louise

MOTHER — 15. Birthplace: Norfolk, Virginia

16. Informant: Mary Rose Rowe

Address: Arundel Road, Rivera Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1947 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street.

19. July 10 1947 (Date rec'd by registrar) A. W. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to July 8 1947 and that I last saw h... alive on July 7 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Degenerative Cardio-Vascular Disease	10 years
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Rivera Beach, Md. Date signed: 7/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05728 P

Reg. Dist. No. 30L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1yr. 8mo. 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yr. 8 mo. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: BALTIMORE COUNTY

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME SAVOY - CHARLES EUGENE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Mrs. Irene Savoy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1908

8. AGE:

Years	Months	Days	If less than one day
39	8	11	hrs. min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER 12. Name: Eugene Savoy

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Hattie ?

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Crownsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-21-47 (month) (day) (year)

Cemetery or crematory: Western Star cem

Location: md

18. Funeral director: George H. Kelson

Address: 1303 Presstman St

19. July 21 1947 (Date rec'd by registrar) R. H. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1947, at 11:35 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 7, 1945 to July 18, 1947 and that I last saw him alive on July 18, 1947

Immediate cause of death: General Paresis — DURATION: Known to us since admission

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: CROWNSVILLE, MARYLAND Date signed: 7/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05729

CERTIFICATE OF DEATH

97

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Jessups.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME James Lemone.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Divorced.

6.(b) Name of husband or wife: Ruth Davis Lemone

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 12 - 1880

8. AGE:

Years	Months	Days	If less than one day
66	8	2	hrs. min.

9. Birthplace: Baltimore - Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Unknown James E. Lemone
13. Birthplace " Maryland

MOTHER
14. Maiden name: Unknown Mary V. Adams
15. Birthplace Maryland

16. Informant: Md. Bureau of Vital Statistics Records
Address Jessups, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-17-47 (month) (day) (year)

Cemetery or crematory: Lincoln Park.

Location: Baltimore Md.

18. Funeral director: Geo. L. Beyard

Address 1512 Hollins St.

19. 7/17 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to — 19—

and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Unknown
Due to: Generalized Arteriosclerosis - Chronic	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Gustave A. Faubert M.D. (City, deputy medical examiner, M.D. or other)

Address Glen Burnie Md. Date signed 7/14/47

75 - 55

55) 1500 (25
110
400

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05730

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: (Near) Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? None
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, 13
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1690 Darley Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VERNA R. SICHELSTIEL (SICHELSTIEL)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph F. Sichelstiel, Jr.
6.(c) If alive, give age: 24 years
7. Birth date of deceased (mo., day, yr.): July 4, 1922

8. AGE: Years	Months	Days	If less than one day
25	0	0	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Own Home

FATHER
12. Name: William Peddicord
13. Birthplace: Ellicot City, Md.

MOTHER
14. Maiden name: Ruth White
15. Birthplace: Baltimore, Md.

16. Informant: Joseph F. Sichelstiel
Address: c1690 Darley Ave, Baltimore, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 7/8/47 (month) (day) (year)
Cemetery or crematory: Balto National
Location: Frederick Rd
18. Funeral director: J. J. Fahey & Sons
Address: 818 Light St.

19. July 4 1947 (Date rec'd by registrar) C. W. Hedrick, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4, 1947, at 5:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....
and that I last saw h.... alive on .... 19....

Immediate cause of death: Fracture of skull and hemorrhage from deep — Duration: sudden
Due to: lacerations of right leg. Compound fractures of
Due to: both legs - below knee. - superficial lacerations of face and forehead.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/4/47
Where did injury occur? Crain Highway - A.A. - near Glen Burnie - Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Crain Highway
Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: [signature] acting medical examiner M. D. or other
Address: Glen Burnie, Md. Date signed: 7/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05731

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Manhattan Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4022 Edmondson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Harry Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hilda M. Smith (nee Gilbert)
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1889.

8. AGE: Years	Months	Days	If less than one day
57	11	7	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business

FATHER
12. Name: Charles R. Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna P. Schmidt
15. Birthplace: Maryland

16. Informant: Hilda M. Smith
Address: 4022 Edmondson Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave. Balto. Md.
18. Funeral director: Harry A. Litzinger
Address: 4101 Edmondson Ave.
19. 7-9 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1947. 19..... at 8.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 41, to July 8 19 47 and that I last saw him alive on July 7, 1947 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	10 mos
Due to	
Due to	
Other conditions Chronic valvular heart disease.	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. E. Wells M. D. or other
Address: 4100 Edmondson Ave. Date signed: 7/8/47

Evidence for change of date of birthshown on Film G110 7/15/47 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10 Oct (2)

05698 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Anne Arundel

City or town: Gibson Island

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: .....

City or town: 732 Light St. Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mary Agnes Sordillo,

3.(b) Social Security Number

4. Sex: female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Joseph L. Sordillo

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 3 ~~1881~~ 1883

8. AGE: Years ~~65~~ 64 | Months 2 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace: Brooklime Mass. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: .....

FATHER — 12. Name: Patrick Ryan

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Cathrine Cahill Ryan

MOTHER — 15. Birthplace: Ireland

16. Informant: Son Joseph Sordille

Address: 732 Light St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1947 (month) (day) (year)

Cemetery or crematory: Holy Cross Cem.

Location: Gov. Ritche Hgy.

18. Funeral director: Frank Della Vecchia

Address: 52 N. Monroe St.

19. July 7 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated, from Post mortem Examination July 1947

Immediate cause of death ..... DURATION

Due to: Hemorrhage

Due to: Ruptured varicose veins in right leg

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md. Date signed 7/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

05732

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundle

City or town: Crownsville (Herald Harbor)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 60 Lincoln Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: LAWSON W. SPESSARD

3.(b) Social Security Number: 214-18-8514

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Jane

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2nd. 1917

8. AGE: Years	Months	Days	If less than one day
30	5	4	..... hrs. ..... min.

9. Birthplace: Smithsburg, Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Raymond B. Spessard
13. Birthplace: Smithsburg, Md.

MOTHER
14. Maiden name: Nita B. Wiles
15. Birthplace: Smithsburg, Md.

16. Informant: R. Kenneth Spessard (brother)

Address: Germantown, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-9-1947 (month) (day) (year)

Cemetery: Arlington National

Location: Arlington Co. Virginia

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. 7/11/47 (Date rec'd by registrar) 19 E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1947 19 ..., at 6p M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ** Postmortem Examination ********** 19 ..... and that I last saw ~~him~~ ** alive on ** July 6, 1947 19 .....

Immediate cause of death	DURATION
DROWNING	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ACCIDENT Date of: 7/6/47

Where did injury occur? Herald Harbor, (City or town) A.A., (County) Md. (State)

Injured at home, farm, industry, public place (where?): Severn River

Means of injury: Drowning Injured at work? No

23. SIGNATURE: Lee M. Caffey M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Maryland Date signed: 7/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52a

05733

FILM No. G 111 AUG 5 - 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural Eastport Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1020 Tyler Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1020 Tyler Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ruby V. Taylor

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Alvin S. Taylor

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1936

8. AGE: Years: 20 21 | Months: 7 | Days: 16 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis Anne Arundel Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Charles U. D. Brady

13. Birthplace: St Mary's Co. Maryland

MOTHER

14. Maiden name: Evelyn Beall

15. Birthplace: Annapolis Md.

16. Informant: Alvin S. Taylor

Address: 1020 Tyler Ave Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1947 (month) (day) (year)

Cemetery or crematory: Cedar Park

Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. July 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to July 26 1947 and that I last saw h[illegible] alive on July 26, 1947

	DURATION
Immediate cause of death	
Due to: Carcinoma of the Rectum (Rectal Cyst)	2 yrs.
Due to:	
Other conditions: Metastasis to all organs of body (Include pregnancy within 3 months of death)	Several Mos.

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed 7/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05735

55b

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Millersville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Severna
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs. Jane Phelps Ward.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: N. Benjamin Ward
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): April 13 - 1904

8. AGE:

Years	Months	Days	If less than one day
43	4	14	....hrs. ....min.

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: William Edward Higley
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Daisy Claud Watkins
15. Birthplace: Annapolis, Maryland.
16. Informant: Mrs. Robert Burns (Sister)
Address: Millersville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July-30-1947 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial
Location: Severn Cross Roads, A.A.C. Md.
18. Funeral director: Thomas W. Dingletow
Address: Glen Burnie, Md.
19. 7-28-1947 (Date rec'd by registrar) T.W.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947 at 10:55 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15 1947 to July 26 1947
and that I last saw h.. alive on July 26-1947 19....

Immediate cause of death	DURATION
Causes of the Spine	2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lemuel B. Barber M.D.
M. D. or other
Address: Glen Burnie Md. Date signed: 7/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05736

83a

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County A.A. Co.

City or town Rural..... Cedar Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? I3 Yrs.

Hospital, institution, or street address where death occurred:
Wells Ave., Cedar Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A.A. Co.

City or town Rural, Cedar Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wells Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Mary Elizabeth Wells

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowerd

6.(b) Name of husband or wife James Wells

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) I883

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace A. A. Co. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name Henry Johnson
13. Birthplace A. A. Co.

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant James A. Wells

Address Wells Ave., Cedar Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/24/47 (month) (day) (year)

Cemetery or crematory Flowlers Chapel

Location Bestgate, Md.

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. July 24 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 19 47, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 19 46, to July 20, 19 47

and that I last saw h alive on July 20, 19 47

	DURATION
Immediate cause of death Cerebral thrombosis	3 days
Due to Arterial Hypertension	for 1Yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. F. Richardson M.D.
M. D. or other

Address Owings Mills, Md. Date signed 7/22/47